THE IMPACT OF CHANGES IN JUDICIAL DOCTRINE: THE ABROGATION OF CHARITABLE IMMUNITY

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Common law doctrines may have as significant an impact on everyday life as those of the U.S. Supreme Court. This paper focuses on the abrogation of the doctrine of charitable immunity, which has occurred in 32 states since World War II. We investigate the impact of this change on average hospital room rate charges in each state. Both static and dynamic analyses are conducted. In both we control for economic and inflationary variables by using state per capita income data. Static analysis involves year-by-year comparison of room rate charges in abrogating states with those in states which retain the doctrine. The results are inconclusive. In dynamic analysis we identify those states which abrogated the doctrine and note changes in their average room rates at periods two, four, and six years subsequent to the abrogations. We also identify states which underwent no change in doctrine over the same periods. The amounts of room rate change in the two categories of states are then compared. We had expected the amount to be greater in abrogating states, and in fact this is almost universally the case. This strongly suggests that abrogation of charitable immunity has produced a demonstrable increase in hospital room rate charges.

The impact of court decisions upon society has been the object of research by political scientists for well over a decade. However, the focus has by and large been limited to (1) decisions of the U.S. Supreme Court, and (2) the so-called public law area. In other words, attention has gone to those salient and dramatic decisions involving such issues as racial desegregation, school prayers, and the rights of criminal defendants. By contrast, political science has virtually ignored the impact of other tribunals. This is particularly true for the common law decisions of state courts.[1]

Common law decisions, however, are very much a part of politics. They often authoritatively determine norms of public behavior and allocation of financial assets and risks. Indeed, as the discipline of political science has now moved into an era of focus on the study of "public policy," it is unfortunate that so

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[1] One exception is Croyle (1977, 1979).

little attention is given to the development and impact of common law doctrines.[2] It might be said, for example, that the abrogation of the common law doctrine of sovereign immunity has had more real political impact than have some notable public law decisions such as the school prayer cases.

To the uninitiated, the common law appears tortoise-like if not completely static. Of course, its ancient *raison d'etre* emphasizes stability and predictability—concepts embodied in the doctrine of *stare decisis*. Nonetheless, as Holmes (1881: 3) reminded us, the life of the common law has been *experience* rather than logic or precedent. Consequently, the courts are constantly being called upon to modify, expand, abrogate or initiate new common law doctrines in response to ever-changing technological situations and social mores. These changes invite systematic policy impact analysis. In deciding to adopt, modify, or abandon common law doctrines, courts necessarily make choices among alternative public policies. In adopting the fellow-servant, contributory negligence, and assumption of risk doctrines, 19th-century courts in England and the United States were essentially deciding to minimize financial risk for developing industrial enterprise and shift much of the social and fiscal burden for industrialization to the working class. Similarly, in abrogating the venerable doctrine of sovereign immunity, courts today are shifting the burden of tort compensation to the solvent party, the taxpayers generally, rather than letting it fall on the comparatively inpecunious state employee at fault, or upon the victim.

While the likely social impact of these choices of doctrinal alternatives seems easily observable, we lack precise systematic data on the actual consequences of such choices.[3] Do state budgets (and perhaps tax rates as well) increase, or do other state functions suffer financially to a greater extent in states where sovereign immunity has been abrogated, compared to those states where it remains in effect? How great is the difference? Alternately, does the change give rise to so few actual or potential lawsuits that its impact upon society is virtually unmeasurable?

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[2] Shapiro (1972) argues that political scientists stayed away from common law decisions largely out of fear of intruding on the domain of law schools. While the primacy he assigns to this reason may be debatable, there is no question that Shapiro has identified a large void in public-policy-oriented research. See also Shapiro (1970).

[3] Croyle (1979) pursues a systematic investigation of the exact dollars and cents costs of alternative products liability doctrines.

I. CHARITABLE IMMUNITY

This paper attempts to measure systematically the impact of various positions on the doctrine of charitable immunity taken by state supreme courts in the years since World War II. Under this doctrine, charitable organizations cannot be sued in tort; victims cannot recover damages from charities for injury caused by the negligence of their employees. The term charitable organization, it should be emphasized, extends beyond the Salvation Army or similar groups rendering charity in the generic sense to encompass nonprofit service organizations generally, such as hospitals, churches, schools and colleges, and YMCA's. In most jurisdictions, charitable immunity is (or was) total. Covered organizations were immune to damage suits.[4] In some jurisdictions, however, immunity was only partial. For example, in some states charitable immunity extended only to "actual recipients of benevolence," e.g., patients who did not pay or only partly paid their hospital bill. In others, immunity covered only the charity's trust fund and derived income, and other charitable donations received, but not monies received for services rendered.

At this point, a brief history of the doctrine is in order. Charitable immunity entered the common law in the middle of the 19th century, most notably in the 1846 House of Lords decision of *Feoffees of Heriot's Hospital* v. *Ross* (12 Cl, and Fin. 507, 8 Eng. Rep. [1508]). It crossed the Atlantic 30 years later when, in *McDonald* v. *Massachusetts General Hospital* (120 Mass. 432 [1876]), the Massachusetts Supreme Court adopted the doctrine. Ironically, the English courts were rejecting the doctrine about this time, and it soon disappeared from English law (e.g., *Foreman* v. *Mayor of Canterbury*, 6 Q.B. 214 [1871]). The doctrine proved popular; seven state high courts had accepted it by 1900, 25 had by 1920, and 40 had by 1938. During this time only one state high court, in Minnesota, rejected the doctrine, while the high courts of nine states (including Alaska and Hawaii) did not rule upon it.

In the course of adopting the doctrine of charitable immunity, state high courts used several legal syllogisms to justify

[4] There were minor exceptions in some states. Sometimes liability was incurred if the damage was inflicted by the board or officers of the charity rather than its employees, i.e., vicarious liability could not be visited upon charities. And sometimes charities were liable to "strangers" (those with whom they stood in no charitable or contractual relationship such as visitors to a hospital or passers-by in front of a YMCA). These exceptions were so minor policywise that states where they existed can fairly be placed in the total immunity category.

their decisions—e.g., that charitable funds were analogous to trust funds and should not be diverted from the intent of the donor (Prosser and Wade, 1971: 1113-1114). But public policy considerations were critical and often frankly recognized (e.g., *Taylor* v. *Flower Deaconess Home & Hospital*, 135 N.E.287 [Ohio 1922] and *Dille* v. *St. Luke's Hospital*, 196 S.W.2d 615 [Mo. 1946]). The Iowa Supreme Court observed, "It is better for the community and the public in general that the individual suffer and bear his loss, rather than that the offending charitable institution should suffer in damages" (*Andrews* v. *YMCA of Des Moines*, 284 N.W.186 [1939: 191]).

In 1942, however, a counter trend began when the doctrine was rejected in the United States Court of Appeals for the District of Columbia, in a devastating opinion written by Judge Wiley Rutledge (*Georgetown College* v. *Hughes*, 130 F.2d 810 [D.C. Cir.]). The opinion achieved widespread notice and served as a catalyst for other courts to reconsider the advisability of maintaining the doctrine of charitable immunity. During the 1950's and 1960's many state high courts abrogated the doctrine. A few accomplished this in two steps, going first to partial immunity and then to no immunity at all. Courts deciding the issue for the first time all rejected the doctrine. By 1975, only seven states retained the doctrine in full, while five more had partial immunity. Thirty-five states had abrogated or rejected the doctrine, while three still had no rulings on the matter. Table 1 describes the history of the doctrine subsequent to the *Hughes* decision.

The decline of the charitable immunity doctrine often was explicitly justified on public policy grounds. Several abrogating courts conceded that the doctrine was justifiable public policy in the 19th century, but that the conditions making it such were no longer operable in the mid-20th century (e.g., *Haynes* v. *Presbyterian Hospital*, 45 N.W.2d 151 [Iowa 1950]; *Pierce* v. *Yakima Valley Memorial Hospital*, 260 P.2d 765 [Wash. 1953]; *Parker* v. *Port Huron Hospital*, 105 N.W.2d 1 [Mich. 1960]). Courts often noted that most charities today were no longer impecunious, low-budget, marginal operations, but often large organizations with thousands of salaried employees operating on modern business principles (e.g., *Foster* v. *Roman Catholic Diocese of Vermont*, 70 A.2d 230 [Vt. 1950]; *Adkins* v. *St. Francis*

Table 1. Changes in the Status of the Charitable Immunity Doctrine, 1942-1974

Year	(1) FI to CA	(2) NPR to CA*	(3) PI to CA	(4) FI to PI	(5) Other
1942		District of Columbia			
1946	North Dakota				
1950	Iowa	Vermont		Illinois	
1951	Arizona California Delaware Mississipi				
1952		Alaska			
1953	Washington		Florida		
1954	Kansas				
1956	Ohio				
1957	Nevada		New York		
1958	New Jersey				
1959					Kansas and New Jersey legislatures reinstate doctrine
1960	Michigan				
1961	Kentucky Wisconsin	Montana			
1963	Oregon				
1965	Kansas** Pennsyl-vania West Virginia		Illinois		
1966	Idaho Maryland Nebraska			Texas	
1967	Connecticut North Carolina				
1968	Indiana				
1969	Massachu-setts Missouri				
1971			Texas		
1974	Louisiana				

States abrogating or rejecting the doctrine prior to 1942: Minnesota, New Hampshire, and Oklahoma

States retaining the doctrine of full immunity during the above period: Arkansas, Maine, Rhode Island, South Carolina, Virginia, and Wyoming

States retaining a doctrine of partial immunity during the above period: Alabama, Colorado, Georgia, Tennessee, and Utah

States which had not ruled on the doctrine through 1974: Hawaii, New Mexico, and South Dakota

*See footnote 10.

**State Supreme Court declared reinstatement statute unconstitutional.

FI = Full Immunity; CA = Complete Abrogation; PI = Partial Immunity; NPR = No Previous Ruling.

Hospital, 143 S.E.2d 154 [W. Va. 1965]). Courts also noted that the risk of crippling verdicts could be minimized and controlled through the purchase of liability insurance, which had been virtually unknown in the 19th century (e.g., *Mississippi Baptist Hospital* v. *Holmes*, 55 So.2d 142 [Miss. 1951]; *Darling* v. *Charleston Community Memorial Hospital*, 211 N.E.2d 253 [Ill. 1965]).

Abandonment of the doctrine was not entirely consensual. Abrogating decisions were frequently accompanied by dissents—sometimes vociferous and lengthy (e.g., *Collopy* v. *Newark Eye and Ear Infirmary*, 141 A.2d 276 [N.J. 1958]; *Flagiello* v. *Pennsylvania Hospital*, 208 A.2d 193 [Pa. 1965]; *Pierce* v. *Yakima Valley Memorial Hospital*, supra). And several state high courts explicitly retained the doctrine in the face of the post-*Hughes* trend (e.g., *Rhoda* v. *Aroostook General Hospital*, 226 A.2d 530 [Me. 1967]; *Decker* v. *Bishop of Charleston*, 147 S.E.2d 264 [S.C. 1966]). The struggle extended beyond the judicial arena. Some legislatures refused to abrogate the doctrine by statute despite judicial invitations to do so, often making clear in debate and vote their preference for retention.[5] Indeed, the Kansas and New Jersey legislatures passed laws *reinstating* charitable immunity following abrogating decisions of their respective supreme courts (Kan. Gen. Stat., 1959, Supp. 17-1725; N.J. Laws, 1959, c. 90).[6] The Kansas law, however, was then ruled unconstitutional by the state supreme court (*Neeley* v. *St. Francis Hospital*, 391 P.2d 155 [1964]).

Impact on Hospitals

Hospitals have been the charitable institution most frequently involved in abrogation decisions. The scope and magnitude of hospitals' activities exceed that of other charitable institutions by a wide margin. The activities of hospitals are such that they are especially prone to tort damage suits.

Accordingly, the most meaningful examination of the effects of the abrogation of the doctrine of charitable immunity will involve its impact on health service institutions. In this paper, we examine hospital room rates across 49 states (lack of data precludes consideration of Alaska). The choice of room rates as our dependent variable rests on several grounds. First,

[5] However, in two states, Connecticut and Nevada, abrogation of the doctrine was accomplished by the legislature rather than the judiciary.

[6] The New Jersey law did allow liability up to $10,000.

in the period of most active abrogation activity, 1950-1974, hospitals were relatively free to set their own room rates. Today, many states have some sort of public rate-setting agency which at least influences these hospital charges. Prior to 1975, however, such agencies were both rare and weak (Colner, 1977). Second, during this same period, room charges accounted for a considerable portion of hospital revenues, and thus figured very strongly in the general fiscal management picture. Today, the situation has changed somewhat. Ancillary charges or costs assessed for specific services make up a much larger portion of hospital income; room fees have become more of an incidental charge (Jankowski, 1977). Finally, room rates represent comparable services for which all hospitals specifically charge. Accordingly, systematic, high-quality, cross-state data exist.

One can envision different consequences brought about by the abrogation of charitable immunity. First, it is possible that the change of doctrine is largely without effect. If there is little potential for damage suits against hospitals, there will be little litigation. Liability insurance will thus not be purchased, or if it is, premiums will be low. Hospital room rates would not be significantly affected. Alternately, if hospitals had been committing a large number of potentially tortious acts upon patients, one could expect the number of suits to increase rapidly; higher costs would thus be imposed on hospitals either in the form of damage awards and legal fees or in sizable insurance premiums. If this were the case, most hospitals would be faced with the necessity of either raising income—accomplished best in this period through increasing room rates—or decreasing services.

Some of the judges who wrote majority opinions in the abrogation cases seem to express the view that the impact would be minimal. Rutledge, for example, argues, "No statistical evidence has been presented to show that the mortality or crippling of charities has been greater in states which impose full or partial liability than where complete or substantially full immunity is given. . . . Charities seem to survive and increase in both with little apparent heed to whether they are liable for torts. . . ." (*Georgetown College* v. *Hughes*, 130 F.2d 810 [D.C. Cir. 1942: 823]). This kind of comment, we might suspect, was directed more toward the doomsday prophecy of defense attorneys than at predicting accurately the effects of the decision. Many events far short of disaster can still have profound implications.

Much sound legal opinion of the time, including that expressed by dissenting judges in some of the abrogation cases, envisioned rather substantial consequences for the hospitals. Justice Burling in New Jersey predicted the demise of the smaller hospitals and clinics (*Collopy* v. *Newark Eye and Ear Infirmary*, 141 A.2d 276 [1958: 296-297]), while Bell in Pennsylvania, predicting a windfall for insurance companies, saw the inevitability of an increase in costs or a decrease in the quality of service (*Flagiello* v. *Pennsylvania Hospital*, 208 A.2d 193 [1965: 210]). The court in the Michigan abrogation case specifically made it clear that the decision was to have no retroactive applicability so as not to expose hospitals which had not had an opportunity to seek insurance protection to potentially ruinous suits.[7]

Suits against hospitals did, in fact, increase dramatically following abrogation (Haydon, 1958; *Hospitals*, 1961: 91). For example, there were five awards of over $150,000 in Illinois shortly after abrogation (Edelman, 1966). The response of hospital administrators was one of deep concern. Hospital associations recommended heavy insurance coverage, and hospitals eagerly purchased it. Elaborate efforts were instituted to advise hospital management about the nature of liability law and how it would affect them (Garber and Tyree, 1957).[8] In Kansas and New Jersey, as already noted, the agitation of hospital administrators resulted in legislative reinstatement of the doctrine of charitable immunity (*Modern Hospital*, 1959).

There is no clear record of the fiscal management decisions which hospitals made in response to abrogation. However, since reduction of services to patients is unlikely, particularly in a period of expanding medical technology and rising public expectations about medical care, it is reasonable to expect that the increased costs of insurance protection were in fact passed on to patients in the form of higher room rates.[9] Further, there is considerable evidence that increasing labor costs during this period were recovered through room rate increases (Frye, 1966;

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[7] See a comment on this provision of the decision in *Modern Hospital* (1961).

[8] Some writers advised that malpractice suits were likely to be directed away from individual physicians and toward hospitals (Shields and O'Brien, 1966).

[9] See the results of an interesting national survey of hospitals carried out in 1976. Insurance costs had generally risen in this year. Fully 61 percent of the hospitals surveyed had increased their charges in response to this increased cost, and an additional 4 percent were planning an increase (*American Family Physician*, 1976).

Hospitals, 1969). The remainder of this article examines the relationship between abrogation of the charitable immunity doctrine and increased hospital room rates.

II. PROCEDURES

Both static and dynamic analyses of the impact of abrogation on hospital room rates were undertaken. Static analysis involves the comparison of rates in states with different policies at given points in time. Dynamic analysis involves assessing the amount of change in room rates over time in the states in which the doctrine was altered compared to the amount of like change in those states where the doctrine remained constant. Comparisons were made in every state at two-, four-, and six-year intervals after each change in doctrinal status.

As the states moved quickly from a nearly unanimous embracing of the doctrine prior to 1950 to a nearly unanimous rejection of it by 1974, maximum variance in doctrinal status occurs between these two years. Accordingly, data from that period are the most appropriate for both static and dynamic analyses.

Room rate data were taken from American Hospital Association publications. In all but two years during this period the Association conducted a nationwide survey of hospitals regarding, among other things, room rates. These data are reported by state in an annual publication which has had various names over the years (*American Hospital Association*, 1950-1975). Mean single room rates for all hospitals are provided or may be calculated.

The status of the doctrine of charitable immunity by state for each year was determined by an examination of controlling cases and, in a few instances, the relevant statutes. Though not without some complexities (noted above), the status of the doctrine in all states could be determined relatively unambiguously. A classification of a) doctrine in full effect, b) doctrine partially abrogated, c) doctrine fully abrogated, or d) no ruling, was employed.[10]

We have already observed that hospital rates are responsive to a number of economic conditions in addition to changes in the doctrine of charitable immunity. In the period under

[10] A few courts rejected the doctrine of charitable immunity despite the fact that there had been no previous ruling on the matter. Logically, no *abrogation* of existing doctrine occurred in these instances. However, in the interest of verbal economy, we will classify states in which this happened with those in which a true abrogation occurred.

consideration, inflation was of particular relevance. A control for economic variables is therefore essential. Unfortunately, no economic indicators comparable to, say, the Consumer Price Index, are available on a state-by-state basis. Indeed, the only reasonable surrogate available on a state-by-state, year-by-year, basis is per capita income. These data are produced by the Bureau of Labor Statistics and are published in the *Statistical Abstract of the U.S.*

III. FINDINGS

Static Analysis

This analysis involved a direct comparison of those states which had retained the doctrine and those which had completely abrogated it at set points in time. States which operated under a partial immunity doctrine, or which had no judicial ruling on the subject, were excluded from this portion of the analysis. For each year in the 1947-1974 period, an analysis of covariance was performed comparing the two groups of states, controlling for state per capita income. The results are expressed in terms of adjusted dollar differences in average room rates between the two categories of states.

We would expect that in all years the average rate in abrogating states would be higher than in those states where the doctrine had been retained. However, in the early years of this period when few states had yet abrogated the doctrine, idiosyncratic factors in those states could produce contrary results. The same also holds for the last few years when the number of states retaining the doctrine was small. Accordingly, we have the most confidence in this expectation for the middle years.

Figure 1 portrays the differences over time. The horizontal line at zero on the vertical ($) axis indicates the point at which there are no differences in the average room rates between the two categories of states. Entries above the line indicate instances in which abrogating states in fact had higher room rates than their non-abrogating counterparts. Entries below the line indicate the opposite, and are inconsistent with our basic hypothesis.

While the general shape of the curve is in accord with our hypothesis—that is, during the middle years abrogating states

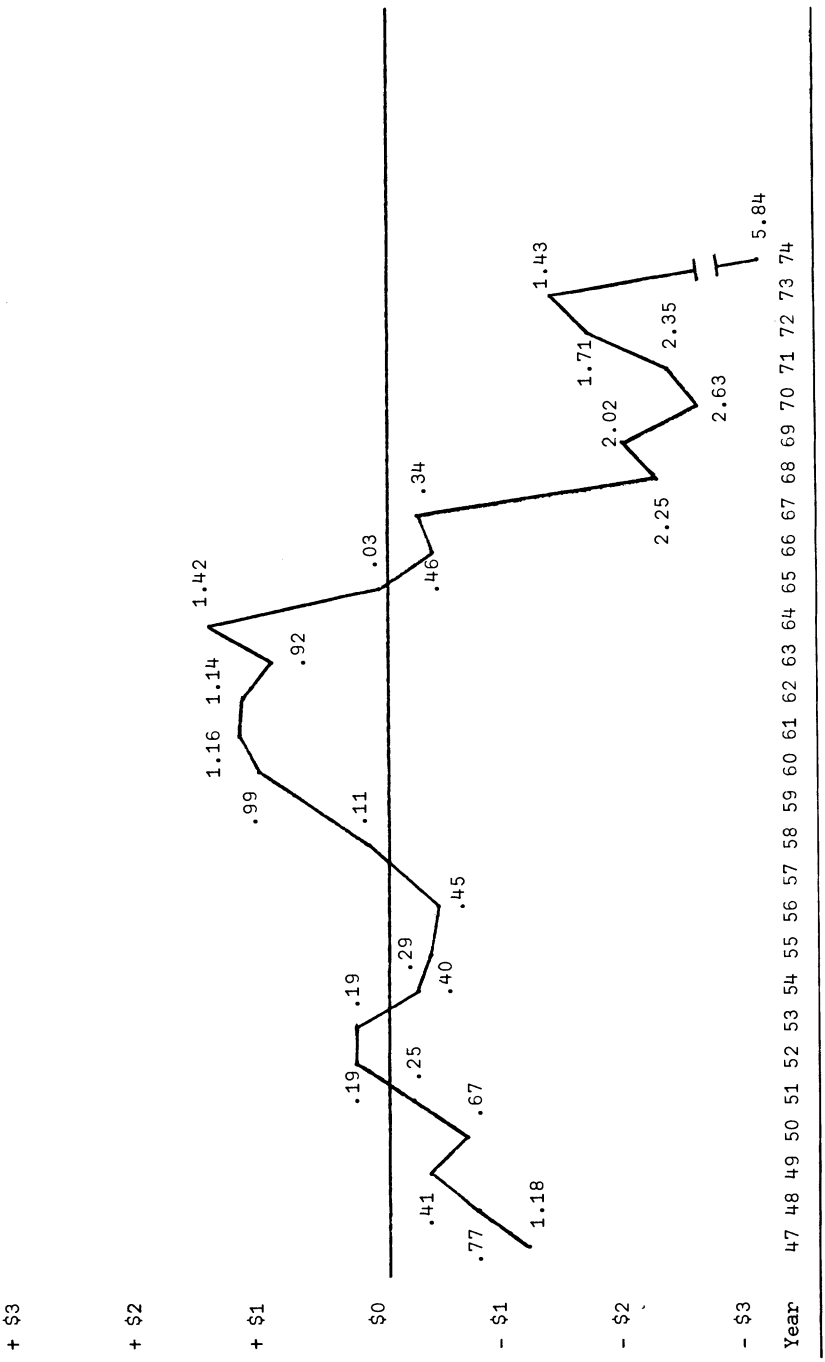

Figure 1. Dollar Differences in Room Rates Between States with Full Charitable Immunity and States with Complete Abrogation

No data available for 1957 and 1959

usually had higher room rates than retaining states—it is nonetheless the case that in 17 out of the 26 years measured, the opposite relationship was observed. Given this circumstance, we must conclude that the static analysis does not lend strong support to our thesis.

Dynamic Analysis

Dynamic analysis rests on the principle that any effects of doctrinal alteration will be manifested at some time subsequent to the actual decision to change. Accordingly, we compared room rates in states that experienced a change from complete immunity to full abrogation with room rates in states in which the doctrine remained stable (regardless of which doctrinal status prevailed) at a time two years after the change. In Table 2 we present the differentials in terms of ratios of the rates in effect two years after the change to those prevailing at the time of the change, controlling for per capita income. That is, a value greater than one indicates that room cost increases over the two-year period have exceeded income increases. See Appendix I for a detailed description of the procedures followed in the dynamic analysis.

Table 2. Adjusted Room Rate Changes over a Two-Year Period

Base Year	Abrogating States	Stable States
1950	1.146 (1)	1.128 (41)
1951	1.097 (4)	1.042 (39)
1953	1.032 (1)	.993 (39)
1954	1.112 (1)	1.026 (38)
1956	1.821 (1)	1.156 (35)
1957	1.221 (1)	1.158 (38)
1960	1.044 (1)	1.040 (40)
1961	1.009 (2)	1.008 (39)
1963	1.020 (1)	.985 (36)
1965	1.174 (3)	1.215 (33)
1966	1.144 (3)	1.107 (32)
1967	1.344 (2)	1.274 (31)
1968	1.111 (1)	1.064 (35)
1969	.902 (2)	.873 (35)

NOTE: Number of states is in parentheses.

There are 14 years in which complete immunity gave way to full abrogation. In 13 of these years there was a greater increase in hospital room rates in abrogating states than in stable states over the ensuing two-year period. The pattern is compelling. If one wished to consider each year in which such an abrogation took place as an independent trial with equal probability that the rate change would be greater in abrogating

or stable states, the probability of such an extreme pattern appearing would be .00086.

It is also noteworthy that while the differences in rate of change do not appear large in absolute terms, they may be quite meaningful in economic terms. For instance, in 1951, there was a 4 percent increase in costs in stable states, adjusting for inflation, but a 10 percent increase in abrogating states. This is a rate change differential of 3 percent per year. In the 1950's, and perhaps even today, such a figure would loom large to economists and government officials, to say nothing of consumers. Clearly the abrogation of charitable immunity has made a visible contribution to increases in hospital room rates.

Similar analyses of four- and six-year periods following changes from complete immunity to full abrogation demonstrate that the impact of this change does not dissipate quickly. After a four-year interval, we find that amount of change in abrogating states is still greater in 10 out of the 14 cases; the figure is 9 out of 14 after six years.

Examination of the three other types of doctrinal change, i.e., from no previous ruling to complete abrogation, from partial immunity to complete abrogation, and from full immunity to partial immunity, shows similar although slightly less impressive results. Combining all three categories for the two-, four-, and six-year periods of analysis, we find that 16 out of 23 comparisons are in the predicted direction.[11]

IV. DISCUSSION

At first glance it may appear anomalous that the dynamic analysis shows convincing evidence of the impact of the abrogation of the doctrine of charitable immunity while static analysis manifests little evidence of such impact. On reflection, however, there seem to be at least three explanations of why this occurs.

First, hospital room rates clearly respond to a large number of variables. Despite our attempt to control for general economic variables by controlling for state per capita income, other factors, including the diffusion of medical technological innovations, remain uncontrolled. Accordingly, only a small portion of variance in hospital room rates is likely to be explained by doctrinal differences at any given point in time.

[11] There are eight changes in these three categories (see Table 1) during the 1950-1974 period, excluding Alaska. This would give 24 opportunities for comparison, but Texas' change to full immunity came so late in the period that we could not obtain data for the time six years later.

Were it possible to impose controls for these manifold variables, our static analysis might well have shown more positive results. An additional consequence of this situation is that increases due to abrogation shown in dynamic analysis would eventually become invisible. We would expect that as the period of time involved in dynamic analysis is lengthened, the impact of abrogation should become less visible; in fact, there is some tendency toward this in the data already.

Second, Croyle's (1977) argument that legal doctrine is but a crude indicator of judicial reality is consistent with our findings. In examining the impact of several legal doctrines on medical malpractice insurance premiums paid, Croyle found negative results. Croyle posits that judges' actions are only loosely controlled by prevailing doctrine. Likely defendants become familiar with the mores of state and local court systems and obtain more accurate assessments of their potential liability than doctrine alone tells them. We feel that even beyond assessing state and local judicial mores, hospital administrators will within a few years after a doctrinal change obtain a working knowledge of the change's real impact—that is, how frequently suits against hospitals are being filed, what amounts are being asked and awarded, etc. At the time of abrogation the dangers may seem considerable and responses may be shaped accordingly, while with time and the accretion of additional information the responses may be modified.

Finally, we can envision anticipatory effects of abrogation. It was clear by the late 1950's or early 1960's that abrogation of charitable immunity was an idea whose time had come. Perceptive hospital administrators in states which had not yet abrogated the doctrine might well have anticipated the inevitable and sought protection against a retroactively effective decision through the purchase of liability insurance.[12] In fact, there is empirical evidence that this phenomenon occurred in at least one state.[13] Not only might this lead to equality of hospital room rates in abrogating and non-abrogating states, but, paradoxically, higher rates in the latter. This could come about if hospital administrators in non-abrogating states, fearing the worst, purchased excessive amounts of costly insurance while their more experienced counterparts in abrogating states were able to effect realistic economies. This may explain the curious

[12] While a few state supreme courts made their abrogation decision nonretroactive, the majority of courts did not.

[13] A recent survey showed that hospitals in Portland, Maine, a state which still retains the doctrine, have purchased liability insurance against negligence claims by patients. See *Maine Law Review* (1973: 373).

pattern in Figure 1 where in the last several years of the period under investigation non-abrogating states did in fact manifest considerably higher room rates.

V. CONCLUSIONS

At a minimum, abrogation of the doctrine of charitable immunity produced a visible response among the immediate consumer population; hospitals raised their room rates in order to meet the potential increased costs implied by abrogating decisions. Indeed, our dynamic analysis showed that the immediate impact of abrogation was quite sizable. On the other hand, static analysis suggests that abrogation of the doctrine does not explain a large portion of the variance in room rates.

Our findings are not unexpected, but they were by no means predictable. For one thing, virtually no information existed on the frequency of hospital-engendered torts. More importantly, however, abrogation occurred across a quarter of a century and a wide variety of jurisdictions. Economic, political, and social factors may well have been sufficiently different across time and space that the impact of abrogation in State A in 1950 would have been quite different from the impact in State B in 1975. Nonetheless, the consistency of our findings indicates that the doctrine's essential components and the reaction of hospitals to it, were common both longitudinally and geographically.

Even if our data are taken to imply a relatively modest impact, they do not suggest its lack of importance. While judges must make decisions on the basis of manifold considerations, one such consideration is surely what they presume to be the societal impact of any proposed change in the law. Indeed, in recent times judges have often overtly discussed such impacts; in the case of charitable immunity, as already noted, expectations of impact were often articulated at some length in judicial opinions. Data such as we have presented here could inform the judges' considerations and thus contribute to intelligent and dispassionate doctrinal development.

Of course, studies such as this contain an element of the chicken and egg problem. Here, for instance, since 36 states have already abrogated or rejected charitable immunity, the data pointing up its clearly visible but undramatic impact are potentially useful only to courts in those 14 states that might yet forswear the doctrine. (It is conceivable, of course, though not very likely, that a court in one of the 36 states might be moved to readopt partial or complete immunity based upon our

findings.) Obviously the impact of doctrinal change cannot be measured until several states make the change—and this is especially so if dynamic rather than static analysis is more illuminative. Thus, courts which are innovators or early adoptors cannot take advantage of more precise measurements and will have to rely on logic or intuition to discern the consequences of their decisional alternatives.

Nonetheless, it is possible to test for the impact of doctrinal change long before the adoption process nears completion. Resulting comparisons could prove quite useful to the many appellate courts who will sooner or later be faced with the necessity of confronting challenged doctrine.

Opportunities of this nature are not lacking. Several major common law doctrines are undergoing challenge nowadays, while others are in a nascent or developmental stage. For example, only about 20 states have adopted the builder-vendor implied warranty doctrine (which presumably will increase housing costs). A similar number have abrogated the accepted work doctrine (presumably increasing construction costs generally), and a smaller group of states has abrogated the doctrine of parent-child tort immunity (which will presumably increase automobile insurance costs). An even smaller number have adopted the "family relationship" criterion for measuring pecuniary damages for wrongful death (also presumably increasing the cost of liability insurance) or the *Great Western* doctrine holding the financier responsible for substandard construction in subdivisions when the developer is insolvent (*Connor* v. *Great Western Savings and Loan*, 447 P.2d 609 [Cal. 1968]). For that matter, the abrogation of sovereign immunity, noted earlier, while approved by about half the states in one form or another, nonetheless remains quite controversial in terms of the nature of its impact on the level of government services and/or tax rates. The same is true with the related doctrine of municipal immunity.

Of course the techniques used for obtaining data about the abrogation of charitable immunity's impact will not always be applicable to a determination of other doctrinal changes. Perhaps for some types of change the impact will simply not be susceptible to measurement. But generally data on such matters as insurance rates, housing costs, and tax levels are available on a state-by-state basis, and researchers can devise techniques to give us greater insight into the development of the common law.

APPENDIX I

Dynamic analysis proceeded according to the following steps:

1. For any given year (hereafter called "base year") from 1950-1974, states in which various kinds of doctrinal change occurred are identified. There are four kinds of doctrinal change: (1) movement from full charitable immunity to complete abrogation, (2) movement from no previous ruling to complete abrogation, (3) movement from partial immunity to complete abrogation, and (4) movement from full charitable immunity to partial immunity. (In addition to the above changes, it would also have been logically possible for a state to move from no previous ruling to partial immunity, but in fact no state did so. Moreover, several kinds of changes in the direction of greater immunity are logically possible. Except for the reinstatement of the doctrine in Kansas and New Jersey discussed in the text, none occurred.)

2. Average room rates for all states in a given category of change are recorded for the base year. Note that this is the rate in effect immediately prior to change in doctrine.

3. For any given base year, "stable" states are also identified. These are states which have experienced no doctrinal change for at least the previous six years and which experience no doctrinal change for subsequent periods of two, four, or six years. These two-, four-, or six-year periods are the time spans across which dynamic analysis is performed.

4. Average room rate is recorded for these stable states for the base year.

5. Average room rates for each category of changing states and for stable states are recorded for the times two, four, and six years subsequent to the base year.

6. The amount of change in each category of changing states and in stable states is adjusted for per capita income change. The formula is as follows: $R = \frac{C_n}{C_o} \div \frac{P_n}{P_o}$, where R = adjusted rate change, C_o = the average room rate cost prevailing in the base year for any group of states, C_n = the average room rate cost prevailing n years subsequent to the base year for the same group of states, P_o = the average per capita income prevailing in the base year in the same group of states, and P_n = the average per capita income prevailing n years subsequent to the base year in the same group of states.

7. The adjusted rates for each category of states are then compared.

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